STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS #28951), at the facility from 5/19/25 through 5/20/25. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. MS #28951 was investigated for resident safety, physical abuse, and resident rights, and F604 was cited. The facility held a license for 110 beds, with a census of 85.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes	F 604		6/11/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/06/2025

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F 604	Continued From page 1 of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility policy review, and record review, the facility failed to ensure a resident was free from the use of a physical restraint when facility staff loosely wrapped a resident's legs in a sheet to prevent the resident from removing his brief for one (1) of three (3) sampled residents. Resident #1 Findings include: A review of the facility policy, "Use of Restraints," revised December 2007, revealed, "...Policy Interpretation and Implementation 1. 'Physical Restraints' are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily...4. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including ...b. Tucking sheets so tightly that a bed-bound resident cannot move ..." A record review of the "Admission Record" revealed the facility admitted Resident #1 on 12/17/24 with diagnoses including Parkinson's Disease. A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/18/25 revealed a Brief	F 604	Preparation and submission of this plan of correction by Pearl River County Nursing Home does not constitute an admission or agreement by the provider of truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirement under the state and federal laws. 1. On May 8, 2025, the tape and draw sheet were immediately removed from the residents bed upon discovery by Licensed Practical Nurse (LPN) #1. An immediate investigation was initiated by the Administrator, Director of Nursing Registered Nurse (RN) and Quality Assurance Registered Nurse (RN). An initial body audit was conducted by LPN #1, with a red area noted, which resolved within one hour. The residents arms and feet were not restricted. Certified Nurse Aides #1 and #2 were suspended pending investigation, and were interviewed by the Director of Nursing. Certified Nurse Aides #1 and #2 stated that the intervention was used because the resident was frequently pulling off his brief and smearing feces. All responsible parties were notified.	

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F 604	Continued From page 2 Interview for Mental Status (BIMS) score of 5, which indicated the resident's cognition was severely impaired. A record review of the medical record revealed there was no documentation indicating Resident #1 had assessments, interventions, or Physician Orders for the use of a physical restraint. A record review of the "Progress Note" dated 5/8/25 at 6:18 (AM) revealed: "AROUND 5:40 AM ON THIS MORNING 05/08/2025 THIS NURSE ENTERED THIS RESIDENT'S ROOM TO OBTAIN VITALS TO ADMINISTER MEDICATIONS. ONCE IN THE ROOM, THIS NURSE NOTICED THIS RESIDENT TUGGING AT HIS SHEET ON HIS LOWER EXTREMITIES...THIS NURSE FOUND THAT THE RESIDENT'S LEG HAD BEEN BOUND TOGETHER WITH TAPE...THE RESIDENT RESPONDED SAYING THANK YOU..." The entry was signed by Licensed Practical Nurse (LPN) #1. A review of the facility's investigation revealed that on 5/8/25, LPN #1 reported to the Director of Nursing (DON) that Resident #1 was found with a sheet wrapped around his legs and secured with tape. Certified Nurse Aides (CNAs) stated the intervention was used because the resident was frequently pulling off his brief and smearing feces. The tape was approximately six (6) inches long and placed mid-calf, over the sheet. The resident's arms and feet were not restricted. A red area was noted by the nurse, which resolved within an hour. On 5/19/25 at 6:15 PM, during an observation, Resident #1 was non-verbal, and was laying in	F 604	Education was completed with staff involved in the incident on May 14, 2025 when allowed to return to work, by the Quality Assurance RN related to Residents Rights, Abuse and Neglect, and Use of Restraints. An Ad Hoc Quality Assurance (QA) meeting was held on May 8, 2025, with members of the QA committee. 2. All residents in the facility have the potential to be affected by the deficient practice. 3. Education with all direct care staff was initiated on May 30, 2025 on Resident Rights, Abuse and Neglect, and Use of Restraints by the Education Nurse LPN and Director of Nursing RN. An audit was performed throughout the entire facility to check for improper use of restraints by the QA Nurse RN on May 13, 2025. 4. Monitoring by the Charge Nurses of improper use of restraints, will be completed on three rooms from Station one and Station two, once per week for four weeks beginning on May 23, 2025; then monthly for three months thereafter. Findings will be brought forth to the Quality Assurance (QA) Committee for analysis and compliance for four months, beginning on June 11, 2025.	

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F 604	Continued From page 3	F 604		

his bed with sheets over his lower extremities. His bed was in the low position with a floor mat next to bed.

On 5/20/25 at 10:00 AM, during an interview with LPN #1, she confirmed she found Resident #1 with his legs wrapped in a flat sheet and a piece of tape. She immediately removed the tape and sheet and notified the DON. She confirmed she did not leave the items in place for a witness to observe.

On 5/20/25 at 10:20 AM, during an interview with CNA #1, she confirmed that she and CNA #2 attempted to prevent the resident from removing his brief by placing him in a "burrito wrap" using a sheet and secured it with tape. She confirmed he could move his arms and legs, and the tape was not in contact with his skin.

On 5/20/25 at 12:24 PM, during an interview with CNA #2, she explained they wrapped the sheet around the resident's lower body and applied a six (6) inch piece of tape across the sheet to keep him from accessing his brief. She confirmed the intervention was not ordered or approved.

On 5/20/25 at 12:30 PM, during an interview with the Director of Nursing, she confirmed the sheet and tape were applied to control the resident's behavior without a physician's order or care plan intervention. She stated the resident retained full movement of upper extremities and feet. There was no injury observed, and there was a reddened area that resolved within one (1) hour. She confirmed the intervention was deemed a violation of policy but not abuse. The CNAs involved received suspensions and re-education.

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F 604	Continued From page 4 On 5/20/25 at 12:45 PM, during an interview with the Administrator, she confirmed the incident was thoroughly investigated and concluded the resident retained the ability to remove the sheet and tape. She emphasized the action was a policy violation, not abuse, and the CNAs were suspended and retrained. She stated the State Agency would have been notified if criteria for abuse had been met. On 5/20/25 at 1:15 PM, during an interview with Registered Nurse (RN) #1 and the DON present, she confirmed that no bruises, scratches, or skin tears were observed. The healing scabbed area on the right calf had been present before the incident. She confirmed the tape did not touch the skin.	F 604		